STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005108	A. BUILDING: _____ B. WING _____	06/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT JENNINGS HOSPITAL INC	301 HENRY ST NORTH VERNON, IN 47265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS JCAHO Surveyor: 33212 Facility Number: 005108 Type of Survey: State Licensure Off Site Joint Commission Accreditation Survey Date of JCAHO On Site Survey - Hospital full survey 6/11-12/2015 Date of ISDH off site review - 11/13/2015 Reviewer/Surveyor -Nancy Otten, RN, PHNS Based on review of the 2015 JCAHO Accreditation Survey Report, it has been determined that St. Vincent JenningsHospital meets the requirements for Hospital Licensure in Indiana for 2015.	S 000		